Supreme Court, U.S.
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No. 92-421

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1992

RICHMOND MEMORIAL HOSPITAL,

Petitioner,

v.

TAJA SMITH, an infant who sues by and through her next friend and mother, Connie Elizabeth Smith, and CONNIE ELIZABETH SMITH, individually,

Respondents.

Petition for Writ of Certiorari to the Supreme Court of Virginia

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF VIRGINIA

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QUESTIONS PRESENTED

1. Whether or not a decision of a state's highest court which overrules a trial court's order sustaining a demurrer and remands for trial on the merits of a case involving an issue of federal law is a final judgment which may invoke the jurisdiction of this Court under 28 USC §1257(a)?

2. Whether or not the Virginia Supreme Court's unanimous decision that the transfer from a hospital of a woman suffering from an emergency medical condition and in labor constitutes patient dumping in violation of 42 U.S.C. §1395dd presents a substantially important federal question which should be settled by this Court at this time when the statute is plain and unambiguous on its face, when no state supreme court except Virginia has yet decided the precise issue raised, when the federal

circuits are not in conflict and Virginia's holding is not in conflict with any decision of this Court?

3. Whether or not a female patient with pre-term rupture of membranes must be admitted to a hospital's emergency room and discharged from the emergency room before she is able to invoke the protection of the patient dumping law, or whether or not a pregnant patient has the protection of the anti-dumping provisions of 42 U.S.C. §1395dd if she is admitted directly to the hospital's Labor and Delivery Suite and is later transferred from Labor and Delivery to another hospital while suffering an emergency medical condition and in labor?

4. Whether or not the COBRA federal cause of action for patient dumping based on strict liability preempts Virginia's medical malpractice Act which requires prior written notice before a medical malpractice

suit can be filed?

RULE 29.1 LIST

The parties are listed correctly in the Appellant's List of Parties. The Appellant states it is a "non-profit" corporation. Richmond Memorial Hospital is exempt from taxation under 26 U.S.C. §501(c)(3) (Internal Revenue Code of 1954), however, it does make a profit[1]. Health Corporation of Virginia, its parent company, is reported to be a profit making entity[2].

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[1] 1992 Annual Report, Volume II, The Data Resource, Virginia Health Services Cost Review Council, p. 145.

[2] See Beverly Orndorff, Hospitals profiting from spinoff firms, Richmond Times Dispatch, December 3, 1990, page A-2, in which it is reported that Health Corporation of Virginia has some fourteen affiliate companies, five of which are for profit operations including a tax entity enterprise, a pharmacy, a collection agency, condominiums, and a retirement community development and management activity.

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Allen Tuten, Administrator
Lincoln General Hospital
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IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1992

RICHMOND MEMORIAL HOSPITAL,

Petitioner,

v.

TAJA SMITH, an infant who sues by and through her next friend and mother Connie Elizabeth Smith, and CONNIE ELIZABETH SMITH, individually,

Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF VIRGINIA

The Respondents, infant and mother, respectfully pray that this Court deny a writ of certiorari to review the judgment and opinion of the Supreme Court of Virginia, entered on April 17, 1992. The style of the civil action was TAJA SMITH, an infant, who sues by

and through her next friend and mother, Connie Elizabeth Smith, and CONNIE ELIZABETH SMITH, individually, v. RICHMOND MEMORIAL HOSPITAL, reported at 243 Va. 445.

OPINIONS BELOW

The opinions below are correctly cited on page 2 of Appellant's Petition.

JURISDICTION

Respondents maintain jurisdiction is improperly invoked under 28 U.S.C. §1257(a).

STATUTES INVOLVED

The statute involved in this case is 42 U.S.C. §1395dd (1988). Respondents maintain that Va. Code Ann. §8.01-581.2 (Repl. Vol. 1992) requiring prior Notice is inapplicable to this federal cause of action.

STATEMENT OF FACTS

The facts are reported by the Virginia Supreme

Court in its opinion (Pet. A-2-5, 243 Va. at 447-448) as follows:

> Connie Elizabeth Smith was admitted to Richmond Memorial Hospital (the Hospital) as a patient on July 18, 1988. Ms. Smith was approximately 33 weeks pregnant and had premature rupture of the uterine membranes. Ms. Smith remained at the Hospital until July 23, 1988.
>
> During the afternoon of July 22, 1988, Ms. Smith complained of abdominal cramping and vaginal leakage. The discharge had turned a greenish yellow color. In the afternoon and again at 10:00 p.m. she was given Nembutal, a hypnotic drug. By 10:00 p.m., Ms. Smith was complaining of irregular abdominal pain and contractions. By 10:30 p.m., her contractions were timed at five minute intervals. At 11:45 p.m., she was taken to the labor and delivery facilities of the Hospital. The vaginal discharge was now dark green in color. By midnight, the opening to the patient's uterus had dilated one centimeter, she had cold chills, and her temperature had dropped to 95.3 degrees Fahrenheit.
>
> At 1:00 a.m., the Hospital called a physician, who ordered that Ms. Smith be transferred to the Medical College of Virginia Hospital (MCV). The physician was not Ms. Smith's regular attending physician, and he gave the verbal transfer order without examining her. Following the transfer order, a nurse began trying to locate an ambulance service to transfer Ms. Smith to MCV. Two services refused, and one was not obtained until the Richmond Memorial Hospital

administrator agreed that the cost of the transfer could be billed to MCV. Connie Smith was taken from the Hospital at 2:10 p.m. and was admitted to MCV at approximately 2:30 p.m. on July 23, 1988.

A medical resident at MCV assessed Ms. Smith's condition to be "(1) prolonged premature rupture of the membranes, (2) pre-term labor at 34 weeks, (3) the Chorioamnionitis should be ruled out, and (4) that there was questionable meconium discharge." At 3:30 a.m., Ms. Smith signed a consent for a caesarean delivery, if necessary. Her contractions were one to five minutes apart at 4:20 a.m. She was taken "emergently" to the delivery room where the child, Taja Smith, was delivered by caesarean operation at approximately 9:48 a.m. Both mother and child suffered substantial injuries. Taja has cerebral palsy and is severely brain damaged.

Premature rupture of membranes seven weeks before a mother's due date is an emergency in and of itself.[3] Additionally, Ms. Smith had given birth

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[3] In Burditt v. U.S. Department of Health and Human Services, 934 F.2d 1362, 1372 (5th Cir. 1991), the court stated: "Every reasonable adult, let alone physician, understands that labor evolves to delivery...". When membranes rupture, the sac surrounding and protecting the baby is removed. The mother and baby become vulnerable to ascending bacteria and infection. At the first sign of infection and/or when the baby's lungs are determined to be mature, reasonable care

previously twice before by Caesarean operation due to cephalopelvic disproportion (head does not fit through the birth canal or labor is dysfunctional); and she had once delivered a still born baby. A Caesarean operation had been planned by the mother's obstetrician for approximately August 18, 1988. The mother had a high-risk pregnancy. She received very little treatment while hospitalized at Richmond Memorial during the five-day period.

On July 22, 1988, the mother became seriously ill. On July 23, 1988, when she alleges she was suffering from an emergency medical condition and was in labor, she was transferred from Richmond Memorial Hospital to MCV Hospital. The doctor who gave the transfer order had never before seen, examined, or heard of Connie Smith. The doctor never came to examine her

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requires prompt delivery.

before transfer; he gave the order to transfer her over the telephone.

The hospital suggests that the transfer was "made in the best interest of the patient" (Pet. 5) but the transfer may have been made because the doctor did not want to come to the hospital or because the hospital wanted to rid itself of a potential liability. The hospital had the capacity to perform Caesarean operations and had pediatricians on staff. Its policy was to transfer women with pregnancies of less than 32 weeks if medically possible but to keep and deliver them at Richmond Memorial if the pregnancy was greater than 32 weeks. (See App. B, Rules and Regulations Division of OB/GYN, Richmond Memorial Hospital, Conduct of Labor, ¶B). Connie Smith was approximately 34 weeks

by dates when transferred[4].

There was no certificate signed by a doctor weighing the benefits and risks of the transfer. There was no physician in the ambulance who could have performed a delivery. The fetal heart monitoring strip at Richmond Memorial was not sent with the mother to MCV Hospital. Respondents have alleged that the transfer was likely to, and did in fact, place the health of Connie Smith and her infant child in jeopardy. They have alleged that a material deterioration of her condition was likely to, and did in fact, result from the transfer. (Motion for Judgment, containing seventeen pages and seventy-one numbered paragraphs, ¶ 68(1), App. D). These are factual issues for a jury. No discovery has been conducted and no evidence has been

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[4] She was 32.5 weeks to 33 weeks on admission five days earlier than transfer. (Pet. B-3). The baby was 36 weeks mature at birth (Pet. B-4).

heard in this case.

Negligence was not pleaded and the sole count in the Motion for Judgment was for illegal patient dumping under 42 U.S.C. §1395dd (also referred to as COBRA). The trial court sustained the hospital's demurrer to the Motion for Judgment without leave to amend. On appeal to the Virginia Supreme Court, that portion of the trial court's opinion which held that prior written Notice of Claim under Virginia's Medical Malpractice Act is not a requirement to bring a federal cause of action under COBRA was affirmed; the trial court's ruling sustaining the demurrer on the ground that a COBRA claim had not been properly pleaded was reversed, and the case was remanded for trial on the merits.

The threshold question in this case is jurisdiction of this Court to review the Virginia Supreme Court decision.

REASONS WHY THE PETITION SHOULD BE DENIED

I. THE JUDGMENT OF THE VIRGINIA SUPREME COURT OVERRULING A DEMURRER IS NOT A REVIEWABLE FINAL ORDER UNDER 28 U.S.C. §1257(A).

A. In civil litigation, the judgment of the highest state court relating to a demurrer or motion to dismiss a complaint is final only if the case is thereby disposed of conclusively.

Congress has limited the Supreme Court's power to review judgments from state courts. Only "final" judgments are subject to review under 28 U.S.C. §1257(a).

In Bostwick v. Brinkerhoff, 106 U.S. 3 (1882), a negligence suit by a stockholder against the directors of a national bank, the Court stated that to be "final", the judgment:

> must terminate the litigation between the parties on the merits of the case, so that if there should be an affirmance here, the court below would have nothing to do but to execute the judgment or decree it had already rendered....If the judgment is not one which disposes of

the whole case on its merits, it is not final. Consequently, it has been uniformly held that a judgment of reversal with leave for further proceedings in the court below cannot be brought here on writ of error. 106 U.S. at 3-4.

In Bostwick, the New York trial court had sustained a demurrer, the New York Court of Appeals had reversed with leave to the defendant to answer the complaint and with direction that the case be returned to the trial court and "proceeded with according to law". The defendant applied to this Court for a writ of error which was denied on the ground that the judgment below was not final because it still remained to be decided whether the defendants were negligent. Similarly, the Virginia Supreme Court has remanded this case to the trial court for further proceedings to determine if the Hospital has violated COBRA. Bostwick was followed in Meagher v. Minnesota Thresher Mfg. Co., 145 U.S. 608 (1892), where the state appellate court had affirmed a trial

court's order overruling a demurrer. Meagher was followed in Werner v. Charleston, 151 U.S. 360 (1894); See also Missouri v. Kansas Interurban Railway Company v. City of Olathe, Kansas, 222 U.S. 185 (1911); Urie v. Thompson, 337 U.S. 163 (1949); Clark v. Kansas City, 172 U.S. 334 (1899); Louisiana Navigation Co. v. Oyster Comm'n of Louisiana, 226 U.S. 99, 57 (1912); *per curiam* opinions in Nichols v. The City of Clevland, 220 U.S. 602 (1910); Meyers, Trustee, Etc. v. Samuels, et. al., 223 U.S. 715 (1911); Clinger, Administratrix, Etc. v. Chesapeake & Ohio Railway Co. of Ky., et. al., 226 U.S. 602 (1912); McCabe, Administratrix v. The Maysville & Big Sandy Railroad Company et. al., 226 U.S. 601 (1912).

No exceptions to these general rules apply in this case. There is no threat of serious diversion of national policies such as a denial of constitutional rights. There

is no need for immediate review of the issue raised. No irreparable harm will suffer if the Petitioner must face trial. The Petitioner has other defenses that it can interpose at trial. Discovery, which has not yet been conducted, could lead to an amendment of pleadings as evidence is developed. The case may be settled at or before trial. The Respondents may lose on the merits and the case may not be appealed to this Court. The Petitioner may lose at trial and may not appeal further.

B. Jurisdiction should not be exercised in piecemeal proceedings. This Court does not render advisory opinions. Smith is not in conflict with any decision of this Court, any other state court or any court of appeals.

This Court has repeatedly stated that jurisdiction should not be exercised in piecemeal proceedings. Louisiana Navigation Co. v Oyster Comm'n of Louisiana, 226 U.S. 99 (1912), *supra*, where this Court stated "the form of the judgment is controlling" and this

Court cannot "disregard the form of the judgment". Since the appellate court judgment order on its face had remanded the cause to the lower court, it was not final and the appeal was dismissed. The form of judgment of the Virginia Supreme Court in this case was: "For the reasons discussed above, the judgment of the trial court will be affirmed in part and reversed in part, and the case remanded for further proceedings." (Petition, A-34-35).

This Court has repeatedly stated that it does not render advisory opinions. Were the Court's reviewing power not limited to "final" judgments, litigants would be free to come to the Court and seek decisions on federal questions which, after later proceedings, might subsequently prove to be unnecessary and irrelevant to a complete disposition of the litigation. Such would be contrary to the interests of judicial economy. The

overruling of a demurrer, like the issuance of a temporary injunction, is not ordinarily a "final" judgment unless some important federal question is involved which is ripe for adjudication. Pope v. Atlantic Coast Line R. Co., 345 U.S. 379, 382 (1953). In Pope, this Court stated "We have not interpreted §1257 so as to preclude review of federal questions which are in fact ripe for adjudication when tested against the policy of §1257". However, in Pope, the state supreme court decision was in conflict with decisions of this Court and was ripe for decision. 345 U.S. at 381. Nothing remained to be done but the mechanical entry of judgment by the trial court; therefore, the court found it had jurisdiction. In this case, to the contrary, there is more to be done than the mechanical entry of a judgment. Discovery and trial remains. There is no need to render an advisory opinion on a statute which is plain on its face.

The decision of the Virginia Supreme Court in Smith is well reasoned and is not in conflict with any other state court of last resort or federal appeals court. The decision is consistent with rulings of a court of appeals. See, Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 270 (6th Cir. 1990). The Virginia Supreme Court cited the language of the Sixth Circuit in Thornton which rejected the Hospital's argument that the Act's requirement of care for a patient did not extend beyond the emergency room to the intensive care and in-patient areas. The court reasoned that COBRA was intended to "insure that patients with medical emergencies would receive emergency care...[which] does not...stop when a patient is wheeled from the emergency room into the main hospital." Id. at 1135. 243 Va. at 452 (Pet. A-20-21).

The Virginia Supreme Court also followed Cleland v. Bronson Health Care Group which held the statute to be clear and unequivocal on its face. Moreover, the Virginia Supreme Court, which is one of the most conservative courts in the country, has not decided a federal question in a way which conflicts with any decisions of the United States Supreme Court. See Sup. Ct. R. 10.

C. The Petitioner's reliance on the fourth exception of Cox Broadcasting Corp. v. Cohn, 420 U.S. 469 is misplaced. No federal policy will be seriously eroded if the Court refuses to immediately review this state court decision.

The Petitioner fails to cite or distinguish the above cited cases but relies on the fourth exception in Cox Broadcasting Corp. v. Cohn (Pet. at 13), applied in Goodyear Atomic Corp. v. Miller (Pet. at 14) and Southland Corp. v. Keating (Pet. at 15).

Cox involved the Constitutional exercise of

freedom of the press in a rape case. No demurrer was involved. A Georgia Statute permitted suit against the press for publishing the name of a rape victim. The Statute was upheld by the Georgia Supreme Court. While the Georgia Supreme Court had remanded the rape case for trial on the merits, this Court noted that delay of review "until after trial...will leave the press in Georgia operating in the shadow of the civil and criminal sanctions of a rule of law and a statute the constitutionality of which is in serious doubt." 420 U.S. at 485-486. For that reason, this Court granted review. However, no such immediacy exists here. No Constitutional question is involved here.

In Goodyear Atomic Corp. v. Miller (Pet. at 14), relied on by Petitioner, neither party contested this Court's appellate jurisdiction. 486 U.S. at 178. No demurrer was involved. That case involved "the only

nuclear facility producing nuclear fuel for the Navy's nuclear fleet." The Ohio decision had "important implications for the regulation of federally owned nuclear production facilities in other States." 486 U.S. at 180. The Ohio ruling, which increased a workers' compensation award for an injury on federal property where an Ohio safety regulation was violated, involved the issue of violation of the Supremacy Clause of the Federal Constitution. Under those circumstances and out of concern that the Ohio decision might seriously erode important federal policy "in the area of nuclear production", this Court granted review of the state-court decision. 486 U.S. at 179. No such issues are involved here.

In Southland Corp. v. Keating (Pet. at 15), no demurrer was involved and the question, like in Goodyear, supra, centered around the Supremacy Clause.

A California Statute invalidated certain arbitration agreements covered by the Federal Arbitration Act which declared a national policy favoring arbitration. Under those circumstances, this Court granted immediate review because a refusal to review might seriously erode federal policy. The Supremacy Clause is not involved in this case. The Federal anti-dumping Statute is clearly written and no irreparable harm will come to hospitals who must comply with the law.

This Court does not have jurisdiction to review under 28 U.S.C. §1257 and should decline the invitation to review this case because (1) this civil action has been remanded for further proceedings on the merits at the trial level; (2) the litigation between the parties has not been terminated by the Virginia Supreme Court's ruling; (3) there may be an amendment to the pleadings; (4) the Petitioner will not be prevented from raising defenses at

trial; (5) there is no threat of serious diversion of national policies such as a denial of constitutional rights; (6) the Virginia Supreme Court's ruling is not in conflict with any decision of this Court or with any decision of any of the Federal Circuits or with other state supreme court decisions; (7) this Court does not render advisory opinions and exercise its jurisdiction in piecemeal fashion; (8) future appellate review by this Court would not be precluded by a refusal to review; (9) no federal policy such as a violation of the Supremacy Clause will be seriously eroded by refusal to review; and (10) there is no substantially important federal question presented.

ARGUMENT

The thrust of the Petitioner's argument is that the mother did not allege she first presented to the emergency room of the hospital (Pet. 21, 26, 30) and

that HCFA's construction does not accord with the Virginia Supreme Court's interpretation of 42 U.S.C. §1395dd (Pet. 31-37, 40, 47-48). The Petitioner also suggests it transferred the mother out of "medical necessity", that it is excused if it transfers a patient to a hospital with superior facilities (Pet. 21, 27) and that the Act does not apply to paying patients (Pet. 21). Furthermore, the Petitioner asserts the Virginia Supreme Court "failed to apply appropriate principles of statutory construction" (Pet. 31). Lastly, the Petitioner maintains that Virginia's Notice of Claim procedure for Medical Malpractice cases is not preempted by the Act.

II. THE ACT DOES NOT REQUIRE AS A PREREQUISITE FOR COVERAGE THAT A PATIENT FIRST PRESENT TO THE HOSPITAL'S EMERGENCY ROOM OR THAT THE DISCHARGE BE FROM THE EMERGENCY ROOM. IT COVERS ANY PATIENT WHO COMES TO A HOSPITAL OR IS A PATIENT AT A HOSPITAL.

The Virginia Supreme Court's literal interpretation of the Act is reasonable. Referring to §1395dd(c) in its opinion (Pet. A-15-18, 243 Va. at 451), the Court stated "If a patient *at a hospital* has an emergency medical condition which has not been stabilized...or is in active labor, the hospital may not transfer the patient" unless certain requirements are met. As stated by the Virginia Supreme Court, "The language used in each subsection [(a), (b) and (c)] describes distinct patient circumstances requiring different treatment protocols. If an individual "comes to the emergency department" [a] the hospital must provide an appropriate medical screening examination...If an individual "comes to a hospital" [b] and the hospital determines that an emergency medical condition or active labor exists, the hospital must stabilize the condition or transfer the person...If a "patient at a

hospital" [c] has an emergency condition or is in active labor, the hospital may transfer that patient only under certain conditions. Id. §1395dd(c)." (Pet. A-17). The Virginia Supreme Court noted "we find nothing in the language of the Act which limits application of these subsections solely to a patient who initially arrives at the emergency room and who has not been stabilized, as the Hospital argues here." 243 Va. at 452. (Pet. A-18). COBRA applies to any individual who has an emergency medical condition or goes into active labor "while at a hospital".

Before the Virginia Supreme Court's decision in Smith was published, a federal district judge in Norfolk, Virginia, decided this precise issue in an identical fashion. In McIntyre v. Schick, M.D. et. al., 1992 WL 134713, Opinion June 16, 1992, the sole basis for the defendant hospital's motion to dismiss was that plaintiffs

"failed to plead, pursuant to §1395dd(a), that Mrs. McIntyre presented to the emergency department of the hospital." That Court stated:

> Although the court agreed that, under subsection (a), one would have to present to a hospital's emergency department in order to state a claim under that subsection, Plaintiffs did not plead their case under subsection (a), and the court reads subsection (a) separately from subsections (b) and (c). Nothing in the language of §1395dd indicates that every other provision in the statute must be read in conjunction with subsection (a), and neither subsections (b) nor (c) refers back to the requirements of subsection (a). Moreover, subsection (b) never mentions the words "emergency department" or "emergency room". See 42 U.S.C. §1395dd(b). The only reference to the "emergency department" in subsection (c) is made with respect to medical personnel permitted to sign a certification of patient transfer. See 42 U.S.C. §1395dd(c)(1)(A)(ii)... .....Nowhere do subsections (b) and (c) state that an individual in an emergency medical condition or in active labor must enter through the emergency room. Nor does the statute state that such a person present in another department of the hospital first must be sent to the emergency room for a determination of that individual's status.

Furthermore, although the terms "emergency department" and "emergency room" were often used in the legislative history of § 1395dd, e.g., H.R. Rep. No. 241, 99th Cong., 1st Sess., pt. 1, at 27 (1986), reprinted

in 1986 U.S. C.C.A.N. 42, 605; H.R. Rep. No. 241, 99th Cong., 1st Sess., pt. III at 6 (1986), reprinted in, 1986 U.S.C.C.A.N. 42, 726-27, other statements in the statute's legislative history demonstrate that legislators were concerned with protecting those in need of emergency medical care, not just those who presented to the emergency room of a hospital. See, e.g., H.R. Rep. No. 241, 99th Cong., 1st Sess., pt. 1, at 27 (1986), reprinted in 1986 U.S.C.C.A.N. 42, 605 ("The Committee is most concerned that medically unstable patients are not being treated appropriately."); 131 Cong. Rec. S13903 (daily ed. October 23, 1985) (statement of Sen. Durenberger ("We cannot stand idly by and watch those Americans who lack the resources be shunted away from immediate and appropriate emergency care whenever and wherever it is needed .... [T]he Medicare program will not do business with any institution which willfully and knowingly, or through negligence, turns its back on an emergency medical situation").

The Sixth Circuit shares this court's view. In commenting on § 1395dd's legislative history, the court disagreed that the repeated use of the term "emergency room" indicated that Congress intended that the requirement to care for a patient in an emergency medical condition extended only to those entering through the emergency room. "A fairer reading is that Congress sought to insure that patients with medical emergencies would receive emergency care." Thornton v. Southwest Detroit Hospital, 895 F.2d 1131, 1135 (6th Cir. 1990).

Although not directly on point, both the Loss v.

Song, No. 89C 6952, 1990 WL 15961 (N.D. Ill. Oct. 16 1990), and Thornton cases support this broader interpretation of the statute. In Loss, a baby whose mother had been admitted to the hospital was born with an emergency medical condition. The plaintiff's doctor released mother and child without first stabilizing the child. The child died soon thereafter from complications arising from his condition. In denying the defendant's motion to dismiss, the court held that the fact that the baby did not come in through the emergency room was not fatal to the COBRA complaint, and that a child with an emergency medical condition, born to a mother admitted to the hospital, must be treated under the provisions of COBRA. Id. at *4.

In Thornton, quoted supra, a patient came to the emergency room after suffering a stroke and was admitted to the hospital. She alleged that her condition was not stabilized while she was admitted, but that she was released anyway. The court held that the provisions of the COBRA anti-dumping statute applied to her, as well, stating:

> Hospitals may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then immediately discharging that patient. Emergency care must be given until the patient's emergency medical condition is stabilized .... Although emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital.

Id. at 1135. Both Loss and Thornton demonstrate that the rationale behind the COBRA patient anti-dumping statute is not based upon the door of the hospital through which a patient enters, but rather upon the notion of proper medical care for those persons suffering medical emergencies, whenever such emergencies occur at a participating hospital. Indeed, it is a ridiculous distinction, one which places form over substance, to state that the care a patient receives depends on the door through which the patient walks.[5]

III. MS. SMITH'S PRESENTATION TO THE EMERGENCY ROOM IS MOOT BECAUSE THE HOSPITAL HAD A POLICY THAT PATIENTS IN LABOR GO DIRECTLY TO LABOR AND DELIVERY.

Ms. Smith was received in the Labor Room by wheelchair at 0600 on July 18, 1988 with spontaneous rupture of membranes. (Exhibit F with trial court brief). The Rules and Regulations of the Division of OB/GYN of the hospital (App. A, Exhibit G, below at 41) required:

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[5]In fact, at the hearing, Defendant VBGH admitted that, had she entered through the emergency room, Theresa McIntyre probably would have been taken to Labor and Delivery anyway.

All pregnant patients of 20 or more weeks gestation who present to Richmond Memorial Hospital with the complaint of labor will be evaluated initially in Labor and Delivery.

The above was called to the attention of the trial court and the Virginia Supreme Court (App. below, 41, 53, App. D).

If Petitioner's contention that a woman must be first admitted through the Emergency Room is correct, then no woman pregnant greater than 20 weeks could ever maintain a COBRA action against Richmond Memorial Hospital because all such patients, like Ms. Smith, are admitted directly to Labor and Delivery. Such a conclusion would lead to other unreasonable results when patients need specialized services. For example, a patient who needs an M.R.I. scan may bypass the Emergency Room and go directly to the Radiology Department. As Petitioner's Appendix G points out, "Some services cannot be made available through an

emergency room or are available only during certain hours because staff are not available at all times." (Pet. G-12).

IV. ADMINISTRATIVE LETTERS AND HCFA INTERPRETATIVE GUIDELINES WHICH DO NOT HAVE THE FORCE AND EFFECT OF LAW ARE NOT MADE PURSUANT TO DELEGATED AUTHORITY AND ARE NOT BINDING ON COURTS. SUCH GUIDELINES WERE NOT MADE A PART OF THE TRIAL RECORD OR THE APPENDIX TO THE VIRGINIA SUPREME COURT

The American Hospital Association has attempted to persuade HCFA to enact regulations favorable to its position. (e.g. Pet. G-27-28)[6]. However, the HCFA has not yet enacted any final regulations.[7]

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[6] e.g., "We believe that our suggestions represent a sensible interpretation of the new requirements..." (G-27) and "We also urge HCFA to reflect these interpretations in its own regulations...." (G-27).

[7] On September 17, 1990, HCFA expected to publish a final regulation "within the next few months." (Pet. H-3). It was reported on May 25, 1992 that HCFA has still not enacted final regulations. See *Hospitals Strictly*

Nonlegislative rules of an Agency (interpretative rules and general statements of policy not made pursuant to delegated authority) are not binding on the courts. Rules which do not have the force and effect of law are subject to challenge in any court proceeding in which their application may be in question. See *Koch*, 1 Administrative Law and Practice §3.4.

Petitioner has attached various letters and guidelines as Appendices to its Petition which were neither made a part of the trial record nor the Appendix to the Virginia Supreme Court. Nor were they argued during oral argument to the Virginia Supreme Court on

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Liable for Patient Injuries, 12 Lawyers Alert 11, May 25, 1992 which comments on this case. Under the law, regulations were required to be completed by Spring, 1987. It has been noted that the Secretary of HHS did not promulgate regulations for the first 26 years of the Hill-Burton program. See Karen I. Treiger, Note, Preventing Patient Dumping: Sharpening the Cobra's Fangs, 61 N.Y.U. L. Rev. 1186, 1217 (footnote 196) (1986), cited by the Virginia Supreme Court (Pet. A-10).

February 24, 1992. These documents were first attached to a Petition to Rehear filed by the Petitioner on May 18, 1992, one month after the Court announced its Opinion and three months after oral argument. Petitioner has now attached these documents to its Petition as if they had been made properly a part of the record below.

HCFA has interpreted COBRA similar to the Virginia Supreme Court's decision in Smith. In an unreported case[8] a physician advised a woman 7 1/2 months pregnant to report directly to the Obstetric Service and to bypass the Emergency Room of a hospital in. It was the middle of the night and the physician called a state hospital which provided charity care. The charity hospital advised the physician that it was full and did not have the capacity at that time to treat the mother

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[8] See Pizza, Patient Transfers-COBRA as Amended, 1992 A.B.A. Sec. Pub. 6 The Health Law Letter 2, p. 4.

and child. Nevertheless, the physician put the mother in an ambulance and transported her to that hospital. The charity hospital reported the physician and his hospital to HCFA asserting that the transfer was not in accordance with subsection (C) of 42 U.S.C. §1395dd. Specifically, they had not agreed to accept the transfer. Although no penalty was levied, HCFA did find that the Act had been violated. It required the hospital to engage in an educational process among its medical staff concerning the requirements of COBRA. HCFA ignored the issue of Emergency Department admission and ruled that admission directly to the Obstetric Department of a woman in labor was the same as an admission to the Emergency Department. Specifically, HCFA stated[9]:

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[9] Letter dated July 5, 1989 from Kenneth C. Schneider, M.D., Associate Regional Administrator for Health Standards and Quality (H.C.F.A.) to Allen Tuten, Administrator, Lincoln General Hospital, App. C, p. 2.

> Your hospital claims that, since the patient in question went directly to the obstetrics department "as an outpatient clinic patient" rather than to the emergency room for her initial evaluation, she did not present to the emergency department, and thus deficiencies should not have been referenced to that department. It is our position that the Emergency Services Condition of Participation (and the medical screening requirements of Section 1867) refer to any organized arrangement for the provision of unscheduled, urgent services, and are not intended to dictate a particular departmental structure. , Lincoln General properly instituted an emergency services record on this patient. (App. C, p. 2).

On page 48 of the Petition, Petitioner states "The construction of a statute by the administrative agency that is charged with the responsibility of enforcing it is entitled to great deference." However, in practice, HCFA's enforcement policy is contrary to the Petitioner's position. Furthermore, the 1992 guidelines are not rules and may be modified at any time (See Pet. E-2 wherein it is stated "Our purpose is to outline the anti-dumping provisions in the statute and not to establish rules subject to the notice and comment

provisions of the Administrative Procedures Act. These instructions may be modified, as necessary, in accordance with the forthcoming final regulations.") (emphasis added).

The Petitioner's reliance on Chevron U.S.A. Inc. v. Natural Resources Defense Council, 467 U.S. 837 (Pet. 48) for the proposition of deference is misplaced. First, that case involved EPA "Regulations" which are mandatory, not merely instructions, guidelines and letters. Less weight is accorded guidelines than administrative regulations which have the force and effect of law. General Electric Co. v. Gilbert, 429 U.S. 125, 141 (1976). Secondly, this Court stated in Chevron "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress". 467 U.S. at 842-843. Thirdly, the Statute

involved in Chevron was silent on the subject at hand and involved interpretation. In this case, the words of the Statute[10] clearly speak to the subject and do not need interpretation. Fourthly, the HCFA guidelines (Pet. F-1) in this case were promulgated on January 29, 1992, six years after the enactment of COBRA[11]. Agency guidelines which are not contemporaneous with the enactment of an Act and which have not been consistently applied over time are not given the same weight as those which are. General Electric Co. v. Gilbert, *supra*, 439 U.S. at 142.

Petitioner relies on a self-serving memorandum from the American Hospital Association dated October,

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[10] for example, "comes to a hospital", "patient at a hospital".

[11] Consolidated Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272, §1921, 100 Stat. 82, 164-67 (codified as amended at 42 U.S.C. §1395dd (Supp. IV 1986). The law was enacted April 7, 1986.

1990 to support a view that the transfer requirements of the Act do not apply to hospital inpatients (Pet. 33-34, F-4-6). An AHA Memorandum is not law. On page 32 of the Petition, Petitioner recites a portion of this AHA Memorandum but omits other relevant AHA statements at F-5-6:

> This does not preclude the possibility that subsequent court judgments may apply the transfer protocols in cases involving inpatients and some hospitals may wish to adopt this broader interpretation pending further judicial action.

The first page of the 1990 AHA Guide (F-2) recites "hospitals must base their compliance action on the statute". (Pet. F-2). The second page states "Each hospital should consult with legal counsel when assessing its compliance with the new requirements." (Pet. F-13). This is a kind way to say "read the statute and cases".

V. THE ACT (42 U.S.C. §1395DD) IS PLAIN ON ITS FACE AND VIRGINIA'S INTERPRETATION OF

THE WORDS OF THE STATUTE DOES NOT SUBVERT THE PURPOSE OF THE LEGISLATION OR LEAD TO AN ABSURD RESULT.

A. While the Act is broader than any or all members of Congress were cognizant of, it is not the place of courts to rewrite a statute which is plain on its face to conform with its notion of efficacy or rationality.

Quoting the Sixth Circuit's language in Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 270 (6th Cir. 1990), and agreeing with this rationale, the Virginia Supreme Court stated (Pet. A-26-27):

> Although the legislative history of COBRA indicates Congressional concern with denial of treatment and inappropriate transfers of indigent persons who come to the emergency rooms of hospitals, the plain language Congress chose does not limit the Act to those circumstances. Many courts called on to interpret the language of the Act have reached similar conclusions regarding the breadth of coverage the statutory language provides, in contrast to the more focused scope reflected in the legislative history of the Act. See e.g., Brooker v. Desert Hosp. Corp., 947 F.2d 412, 414-15 (9th Cir. 1991); Gatewood, 933 F2d at 1040; Lee by Wetzel v. Alleghany Regional Hosp. Corp., 778 F. Supp. 900, 902 (W.D. Va. 1991); Delaney v. Cade, 756 F. Supp. 1476, 1485-86 (D. Kan. 1991). As stated by the court in Cleland v. Bronson Health Care Group, Inc.:

> The words of the statute....are quite plain, and interpreting them as such does not lead to an absurd result. It leads to a result considerably broader than one might think Congress should have intended, or perhaps than any or all individual members of Congress were cognizant of. However, it is not our place to rewrite statutes to conform with our notions of efficacy or rationality. That is the job of Congress....Here, the result we reach in no way vitiates or is contrary to Congress's indicated concern in passing the legislation. It may go further than what Congress contemplated, but that is not a reason to distort or excise the words that Congress wrote. 917 F.2d at 270.

COBRA has been interpreted broadly by federal courts and not narrowly in disregard of the plain meaning of the Statute. Thompson v. St. Anne's Hospital, 716 F. Supp. 8, 10 (N.D. Ill. 1989); DeBerry v. Sherman Hospital Association, 741 F. Supp. 1302, 1307 (N.D. Ill. 1990); Burroughs v. Turner Memorial Hospital, 762 F. Supp. 762, 842 (W.D. Ark. 1991). If a statute is clear and unequivocal on its face, it is not necessary to resort to legislative history as Petitioner attempts to do (Pet. 40-46). Brooker v. Desert Hospital Corp., 947 F.2d 412,

414 (9th Cir. 1991), cited by the Virginia Supreme Court (Pet. A-25-26).

B. Whether or not a patient has insurance or is able to pay for his hospitalization is irrelevant to COBRA coverage.

COBRA draws no distinction between persons with and without insurance. Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1040 (D.C. Cir. 1991). The Statute clearly provides that it applies to anyone who comes to a hospital "whether or not eligible for benefits (Medicaid) under this title." 42 U.S.C. §1395dd(b)(1). Petitioner's suggestion that Ms. Smith was "covered by health insurance" (Pet. 10) and that "she was transferred to MCV because she was uninsured or unable to pay" is irrelevant (Pet. 21).

C. Further statements made in the Petition are irrelevant to this inquiry.

It is irrelevant that Ms. Smith was "one centimeter dilated" on transfer (Pet. 8-9). The Act, 42

U.S.C. §1395dd(e)(1)(C), defines active labor to include a transfer which "may pose a threat [to] the health and safety of the patient or the unborn child." In Burditt v. U.S. Department of Health and Human Services, 934 F.2d 1362, 1369 (5th Cir. 1991), the court stated "This statutory definition renders irrelevant any medical definition of active labor." and that the provisions of the Act protect "women in labor who have any complication with their pregnancy regardless of delivery imminency".

It is irrelevant that the infant was born "more than seven hours after arrival" at MCV (Pet. 9). Whether or not transfer "may pose a threat...depends on whether the woman in labor has any medical condition that could interfere with the normal, natural delivery of her healthy child". The Act protects against a "possible" threat. 934 F.2d at 1370. Premature rupture of membranes, the likely need for a repeat Caesarean operation and

chorioamnionitis, conditions affecting the mother in this case, are conditions which can interfere with the normal, natural delivery of a healthy child. As noted by the Executive Vice-President of the AHA (Pet. G-14), "In such a case, 'stabilization' would require delivery of the baby." There is a clear intention on the part of Congress to protect the unborn child.

It is irrelevant if the hospital may believe the transfer was in the "best interest of the patient" (Pet. 5). "Transfer" refers to the illegal "movement" of a patient. 42 U.S.C. §1395dd(e)(5). What is strictly prohibited by the Act is the failure to provide "treatment" of an emergency medical condition or to provide treatment for the labor and the inappropriate "transfer" of a patient with such conditions without the "certification" required. 42 U.S.C. §1395dd(c)(1)(A)(ii). The Statute does not require that an improper, or nonmedical, motive for

transfer be proved as an element for transfer. 934 F.2d at 1373.

It is irrelevant that "Dr. Jones gave the order for Connie Smith's transfer" (Pet. 8). Hospitals can "act and know things only vicariously through individuals". Any violation of the Act by a "physician is also a violation by the hospital". 934 F.2d at 1374.

The Statute does not excuse a transfer to a better-equipped hospital. If such were the case, there could never be a case of patient-dumping when the transfer is from a Level I to a Level II or from a Level II to a Level III hospital. The higher level hospital is always better equipped. In Owens v. Nacogdoches County Hosp. Dist., 741 F. Supp. at 1370 (cited by Petitioner at Pet. 24), the court found the argument that the transfer was to a Level III hospital with a neonatal unit to be "unavailing". In Lee by Wetzel v. Alleghany Regional

Hosp. Corp., 778 F.Supp. 900, 902 (W.D. Va. 1991), the transfer was to a "better equipped hospital", but was held to be covered under the Act. The issue is not whether the transferee hospital is better equipped, but whether or not the transfer took place at a potentially dangerous, and therefore, impermissible point in time and whether or not the treat or transfer requirements were met.

There is no proof of any relationship between "the skyrocketing cost of malpractice insurance" as suggested (Pet. 20) and patient-dumping claims, all of which arose after 1986. Insurance rates were a problem before then and must be related to something else. There is no basis to suggest this is a "meritless suit". (Pet. 20). The Statute imposes a strict liability standard. Stevison v. Enid Health Sys., Inc., 920 F.2d 710, 713 (10th Cir. 1990).

The Court should deny the Hospital's Petition

because (1) the plain language of COBRA does not require that a patient first present to an emergency room before the patient is entitled to coverage; (2) that point is moot in this case; (3) the plain language of the Act applies to any patient who "comes to a hospital" or is "at a hospital"; (4) Virginia's interpretation of the Act does not subvert the purpose of COBRA or lead to an absurd result; and (5) the Court should give no deference to HCFA letters and guidelines not properly made a part of the record below and which do not have the force and effect of law.

VI. COBRA WHICH CREATES A FEDERAL CAUSE OF ACTION BASED ON STRICT LIABILITY AS DISTINGUISHED FROM AN ACTION FOR MEDICAL MALPRACTICE PREEMPTS VIRGINIA'S REQUIREMENT OF PRIOR WRITTEN NOTICE APPLICABLE TO VIRGINIA MEDICAL MALPRACTICE ACTIONS.

COBRA does not preempt state law except to the extent any state or local law directly conflicts with its

provisions. §1395dd (f). Since COBRA has no notice requirement, Virginia's mandatory requirement of notice is a procedural hurdle in direct conflict with COBRA. Both the trial judge and the Virginia Supreme Court unanimously held that the Notice provision is inapplicable to a COBRA federal cause of action. 243 Va. at 455-457 (Pet. A-30-35, B-12-15). As noted by the Virginia Supreme Court, "The Virginia notice provisions not only require a plaintiff to provide written notice of the claim to the health care provider, they also absolutely prohibit the filing of a medical malpractice claim against the health care provider until 90 days after such notification and, if the health care provider chooses to have the issue reviewed by a malpractice review panel, the suit cannot be filed until the panel completes its review. Code §8.01-581.2(A). The state statute of limitations is tolled during this period. It is this aspect of

the notice of claim provision which is in direct conflict with the provisions of COBRA." 243 Va. at 456.

42 U.S.C. §1395dd(d)(3)(C) provides for a federal limitation period of two years to bring a civil action under COBRA.

Relying on Burroughs v. Turner Memorial Hosp., Inc., 762 F. wpp. 840, 843 (W.D. Ark. 1991), the Virginia Supreme Court held that "the tolling provision of the state statute cannot act to toll the running of the statute of limitations established in federal legislation which created a federal right of action." 243 Va. at 456. Burroughs, citing Garrison v. International Paper Co., 714 F.2d 757, 759 n. 2 (8th Cir. 1983) and Holmberg v. Armbrecht, 327 U.S. 392, 395 (1946), held that "the claims on which the statute of limitations is extended are only those to which a statute of limitations determined by *state law* applies." (emphasis added). 762 F. Supp. at

843.

Petitioner cited a footnote in a secondary source as authority for its assertion that "Where a federally created cause of action is filed in state court, state procedural rules regarding commencement and tolling apply, even where the statute of limitations is federally prescribed." (Pet. 53). Petitioner did not discuss the case cited in the footnote. The case referred to in the footnote[12] is a state case which involved the federal Portal-to-Portal Act which specifically incorporated the "period prescribed by the applicable State statute of limitations". Sauerzopp v. North American Cement Corporation, 92 N.E.2d 617 (N.Y. 1950). COBRA does not borrow or incorporate state limitation periods. Exceptions to the general rule that the federal limitation

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[12] 2 J. Moore, J. Lucas, H. Fink, & C. Thompson, Moore's Federal Practice ¶ 3.09[2]n. 15 (2d ed. 1991) (Pet. 53).

period applies and is not tolled by state statutes do not exist here.[13] In Felder v. Casey, 487 U.S. 131, 138 (1988), this Court held that a state's notice of claim statute was inapplicable to a claim brought under 42 U.S.C. §1983 because it would conflict with 42 U.S.C. §1983's purposes and objectives and would frequently and predictably produce different outcomes in §1983 litigation based solely on whether the action is brought in state or federal court. Adherence to such a notice requirement would also burden the exercise of the federal right and would be inconsistent with the compensatory aim of federal civil rights laws. Similarly, Virginia's notice requirements applicable to state medical malpractice actions would burden the deterrent and compensatory aims of COBRA by delaying the filing of

[13] e.g., improper venue, misrepresentation, or war has prevented a plaintiff from bringing his suit. Burnett v. New York Cent. R. Co., 380 U.S. 424, 428-29 (1965).

COBRA actions in state courts and by delaying an award of compensation to the patient who is illegally dumped. Virginia's notice requirement is a procedural hurdle to a plaintiff not contemplated by Congress, and if permitted, would produce different outcomes based solely on whether the action was brought in state or federal court.

Virginia's Medical Malpractice Act is substantively irrelevant to a COBRA claim. The giving of notice under Virginia's Medical Malpractice Act merely triggers the appointment of a medical malpractice review panel, if requested by any party. The plaintiff who wishes to proceed may not file a civil action until 90 days after giving Notice (if no panel is requested) or 90 days after the decision of the Panel if a panel is requested. (Pet. A-32). Panel proceedings often delay medical malpractice cases from a few months to a year in Virginia. When there is a trial, the opinion of the

Panel is admissible into evidence but is not binding on the jury.

The Virginia medical malpractice standard of care is irrelevant to a federal COBRA action in which the only issue is whether or not there has been a violation of 42 U.S.C. §1395dd. Nowhere in COBRA does it state that a state malpractice review panel is permitted to pass on the issue of a COBRA violation before suit can be brought. Nowhere in COBRA does it state that the opinion of a medical malpractice review panel is admissible into evidence at trial.

Additionally, the Panel must apply Virginia's "statewide" standard of care applicable to medical malpractice cases. Under Virginia law, "standard of care" means that degree of care practiced by a health care provider "in this Commonwealth". Va. Code Ann. §8.01-581.20A. Before the enactment of COBRA, the standard

of care in Virginia and elsewhere did not require a hospital to treat a patient or prohibit the hospital's transfer of a patient. Thornton v. Southwest Detroit Hosp., *supra*, 895 F.2d at 1133. The Virginia "standard of care" is irrelevant to a federal COBRA claim.

Petitioner's suggestion (Pet. 50) that Virginia's Notice provision applies to this federal action because Virginia's Medical Malpractice Act applies to "any tort" is also not persuasive. Va. Code Ann. §8.01-581.1. The remainder of the definition in the Virginia statute qualifies "any tort" as one "based on health care or professional services rendered, or which should have been rendered by a health care provider to a patient." 42 U.S.C. §1395dd(e)(5) restricts transfers of certain patients. "Transfer" refers to the "movement" of a patient. The "movement" of a patient in violation of COBRA is not "malpractice" as defined in Virginia's

Medical Malpractice Act and is not a violation of the Virginia standard of care.

The federal district court in Northern Virginia has held that Virginia's notice requirement is a "procedural obstacle" that would "seem to be directly at odds with the purpose, the structure and the language of [COBRA]". Toliver v. Culpepper Memorial Hosp., C.A. No. 90-0501-A, slip op. (E.D. Va. Au. 30, 1991), relied on by the trial judge in Smith (Pet. B-13-14). Another federal judge in the Eastern district of Virginia recently held that Virginia's total medical malpractice cap of one-million dollars, like the notice requirement, does not apply to federal COBRA actions. That judge noted that the cap would have the same potential to frustrate the goals of deterring "patient dumping" and compensating victims as would the notice requirement. Susan M. Power v. The Arlington Hospital, 1992 WL 210588

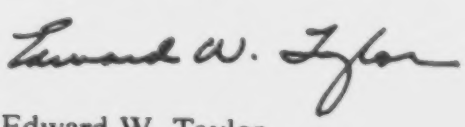
(E.D. Va. August 28, 1992).

The Court should deny the Hospital's Petition because Virginia's Notice requirements applicable to Virginia Medical Malpractice proceedings do not apply to this federal cause of action which establishes a two-year federal limitation period.

CONCLUSION

For the reasons stated above, the Hospital's petition for certiorari should be denied.

Respectfully submitted,



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October 2, 1992

APPENDIX A

RICHMOND MEMORIAL HOSPITAL

RICHMOND, VIRGINIA

RULES AND REGULATIONS

DIVISION OF OB/GYN

Approved: /s/ James E. Jones, Jr.

James E. Jones, Jr., M.D.

Chairman, Division of OB/GYN

/s/ Laurie E. Rennie

Laurie E. Rennie, M.D.

President, Professional Staff

/s/ James Watkinson

James Watkinson

Chairman, Board of Trustees

Reviewed and Approved:

January 1988

4. Elective Inductions--these may be done from Monday through Friday, exclusive of holidays. They should not be started before 7:30 a.m. or after 4:30 p.m. If the above rules delay the induction beyond the 4:30 p.m. cut off time, the induction may be started whenever the personnel is available.

5. Any admission to the Ob/Gyn service shall be seen by the attending physician within a reasonable period of time.

ARTICLE III

A. LABOR AND DELIVERY

1. Delivery Room #3 will be used as a birthing room. Rules and Regulations will be drawn up according to State of Virginia guidelines and approved by the division.

2. Vaginal examinations shall be done under sterile precautions on all patients in labor or thought to be in labor, or for the purpose of rupturing membranes.

3. Gowns shall be worn by all those attending patients in the labor area, and these shall not be worn out of the labor area. Boots or conductive shoes should also be worn in the Delivery Room.

4. Appropriate apparel should be worn by all people in the Delivery Room.

5. All ancillary personnel entering this area should put on Delivery Room gowns before proceeding across the red line separating this area from the dirty area.

6. Babies leaving Labor and Delivery shall be transported directly to the nursery in

an enclosed Armstrong Unit or in a resuscitator.

7. Under no circumstances should an attempt be made to dely the imminent birth of a child, either by physical restraint or deep anesthesia.

8. When nursing personnel are busy in Labor and Delivery area, the attending physician who has a patient in labor at the time should be notified if it would be impossible for them to suitably watch her.

9. All pregnant patients of 20 or more weeks gestation who present to Richmond Memorial Hospital with the complaint of labor will be evaluated initially in Labor and Delivery. L & D personnel will contact the physician for evaluation

instructions. As part of this evaluation, patients will be evaluated for cervical dilitation and fetal monitoring for an appropriate period of time as determined by the physician. The L & D nurse will contact the physician with the report of the observation period. The physician will determine the disposiiton of the patient and will review and sign the record of such disposition within 24 hours of the patient's arrival.

APPENDIX B

RICHMOND MEMORIAL HOSPITAL

RICHMOND, VIRGINIA

RULES AND REGULATIONS

DIVISION OF OB/GYN

Approved: /s/ James E. Jones, Jr.

James E. Jones, Jr., M.D.

Chairman, Division of OB/GYN

/s/ Laurie E. Rennie

Laurie E. Rennie, M.D.

President, Professional Staff

/s/ James Watkinson

James Watkinson

Chairman, Board of Trustees

Reviewed and Approved:

January 1988

ARTICLE VI

RULES REGARDING SPECIAL DRUGS

A. Induction or augmentation of labor with oxytocin may be initiated only after a responsible physician has evaluated the patient, determined that induction or augmentation is beneficial to the mother or fetus, recorded the indication, and established a prospective plan of management. A physician should examine the patient vaginally immediately prior to the oxytocin infusion. The use of oxytocin on labor and delivery should follow the following protocol:

1. Establish a functional IV line.
2. Mix 10 units of oxytocin in 1 liter of IV fluids (preferably a balanced solution D51/2NS, D5RL, D5NS, etc.)

3. Use a constant infusion device to administer the oxytocin starting at lmU per minute. The rate can be doubled every 15 to 20 minutes until good contractions are elicited.

4. While oxytocin is being administered, the patient should be constantly monitored for adequacy of contractions and frequency of contractions. Fetal heart rate should also be monitored continuously. Personnel who are familiar with the effects of oxytocin and able to identify both maternal and fetal complications should be in attendance while oxytocin is being administered. A qualified physician should be readily accessible to manage any complications that may arise during

infusion.

B. All patients started on Apresoline or Yutopar should be seen within a reasonable period of time.

ARTICLE VII

CONDUCT OF LABOR

A. Patients who are admitted to the Labor Room in active labor or those being prepared for induction of labor shall be assigned to a labor room. Their care and supervision shall be carried out by the Labor Room personnel under the direction of the attending physician. All orders during labor shall be given by a physician. In those cases where an attendant of the patient is admitted to the Labor Room, the attendant shall be properly gowned and under the direct supervision of the nursing staff. The attendant is allowed the privilege of

admission to the Delivery Suite only with the permission of the obstetrician.

B. It is recommended that patients presenting with active labor and gestational ages between 24 and 32 weeks be transferred in utero to the Medical College of Virginia if medically possible.

APPENDIX C

July 5, 1989

Allen Tuten, Administrator
Lincoln General Hospital
Post Office Drawer 1368
Ruston, Louisiana 71273

Dear Mr. Tuten:

In a letter dated June 19, 1989, representatives of Lincoln General Hospital requested an informal administrative review of our institution of termination action based upon the State agency's June 14, 1989 finding of noncompliance with Medicare Conditions of Participation. Your hospital challenges the State survey finds in regard to each of the three Conditions cited: Compliance with Federal, State, and Local Laws because of a violation of Section 1867 of the Social Security Act, the so-called COBRA anti-dumping requirements; Quality Assurance; and, Emergency Services.

You allege that Lincoln General Hospital has taken measures to prevent recurrence of incidents which may violate Medicare patient transfer requirements, and that it has strengthened its quality assurance program. In the belief that your emergency department was always in compliance with the Medicare Condition of Participation, you state that no specific changes were made except to implement improvements in transfer protocols, record-keeping, and in the monitoring of transferred patients.

Your hospital's attorney rejects any assertion that the physician who directed the transfer of the patient in question was the "responsible physician" under Section 1867, since he was not a hospital employee and he had no contractual obligation to assume professional responsibility for the transfer of patients. While the definition of "responsible physician" is important in determining possible eligibility for civil monetary penalties assessed by the Office of Inspector General, it does not bear upon HCFA action to terminate the provider agreement. At issue in our determination is whether the transfer of the patient was "appropriate...in which the receiving facility...has agreed to accept the transfer of the patient and to provide appropriate medical treatment...."

In reaching our conclusion that the transfer was not "appropriate," we did take into consideration the fact that Lincoln General Hospital lacked the capacity to provide optimal continuing care for high-risk newborns, and usually transferred such infants, or women in labor who were expected to deliver infants requiring admission to a Newborn Intensive Care Unit, to other, properly equipped hospitals.

However, we found that, following refusal by LSU Medical Center to accept the patient in question, Lincoln General Hospital did not contact other, equally accessible hospitals, which might have agreed to accept the transfer. This happened because Lincoln General followed an established pattern of utilizing LSU for all indigent and Medicaid patients. Further, since the patient was in "active labor" as defined in Section 1867 (because the transfer may pose a threat to the health and

safety of the unborn child), and the transfer was physician-directed, there should have been certification by a qualified medical person that the benefits expected from the transfer outweighed the increased risks. This was not provided.

Your hospital claims that, since the patient in question went directly to the obstetrics department "as an outpatient clinic patient" rather than to the emergency room for her initial evaluation, she did not present to the emergency department, and thus deficiencies should not have been referenced to that department. It is our position that the Emergency Serv ices Condition of Participating (and the medical screening requirements of Section 1867) refer to any organized arrangement for the provision of unscheduled, urgent services, and are not intended to dictate a particular departmental structure. Indeed, Lincoln General properly instituted an emergency services record on this patient.

After considering the information provided by Lincoln General Hospital, it is our position that the State survey agency properly cited deficiencies in the Quality Assurance and Emergency Services Conditions of Participation. The State's finding that there was a violation of the "appropriate transfer" obligations of Section 1867 is affirmed, and it is noted that a physician also failed to certify that the benefits of the transfer in question outweighed the risks. Because of the good faith efforts made by the hospital to avoid a violation in this case, we believe that the gravity of the deficiency is mitigated. Our revised opinion is that the hospital is in substantial compliance, and we will not act immediately to terminate the provider agreement.

Lincoln General provides evidence that it has taken substantive actions to inform medical staff members of the COBRA transfer requirements and the steps being taken to assure the hospital's future compliance. These include a proposed amendment to the medical staff bylaws, a revised interhospital transfer form to assure certification by a physician that the risks of a transfer are outweighed by the benefits, and a broadened transfer protocol to cover all transfers, whether or not they originate in the emergency room. You provided copies of letters to other area hospitals with more advanced neonatal intensive care services, proposing interhospital patient transfer agreements. Further, you describe a recent case (June 7, 1989) to illustrate protracted, but successful attempts to secure an appropriate transfer for a high-risk premature infant.

In our opinion, the measures already underway at Lincoln General Hospital should be sufficient, when fully implemented, to safeguard against further violations of Section 1867. Therefore, the hospital will retain its "deemed status" and will not be subject to a full survey by the State agency. In order to verify the success of the corrective action, the State will perform a limited follow-up survey in approximately two months. Of course, the hospital will be expected to maintain compliance with all the Medicare Conditions of Participation.

Sincerely,

Kenneth C. Schneider, M.D.
Associate Regional Administrator
for Health Standards and Quality

cc:
Ricardo M. Guevara
Normand F. Pizza
bcc:
M. Chunn
official/reading files
KcS/JDS/JJP
DHSQ/KSchneider/ab/7/5/89/76301
ARA-VII

APPENDIX D

(Excerpt of transcript in trial court made a part of Appendix of Virginia Supreme Court.)

each point. I know Your Honor is busy. But, it seems to me that their major point is that indigency has to be alleged. I think the cases that we have cited take care of that. The second point they make is the transfer has to be from an emergency room to another hospital. The facts in this case are that this lady's water broke, she was premature, she was about 33 weeks pregnant approximately, that her water broke at 3:00 in the morning. She's 28 years old. She called her doctor and told her doctor she was going to a hospital. It was not her first baby. She knew what to do when her water broke. And she knew it was a serious matter. She went in the hospital. <u>They have a policy at Richmond Memorial Hospital that everybody who is 20 weeks or more pregnant goes to the labor and delivery room. She</u>

went in to the emergency room, but just walked through, if you will, because they take them directly to labor and delivery. And she stayed in labor and delivery then the entire day. And then she went back to labor and delivery later when she was transferred -- she was transferred, as I understand the facts now as I look at it, and understand no evidence has been taken in this case, there has been no discovery, there have been no depositions taken, our information comes from our client and from the medical records that we reviewed prior to filing this action. But, it appears based on the medical records that she was wheeled to the labor and (emphasis added).

FILING AND MAILING CERTIFICATE

I hereby certify that on this 2nd day of October, 1992, I filed 40 copies of a Brief in Opposition to the Petition for Writ of Certiorari the Clerk's Office of the Supreme Court of the United States and further certify that I mailed via first class mail, postage prepaid, the required three (3) copies to Judith B. Henry, Crews and Hancock, 700 East Main Street, Suite 1015, P.O. Box 1474, Richmond, Virginia 23212-1474. The necessary filing and mailing was performed in accordance with the instructions given me by counsel in this case.

Barbara P. Deane

Lawyers Printing Company
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Richmond, Virginia 23219